

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2011	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK				STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN46254			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	<p>This visit was for the Investigation of Complaint IN00093147.</p> <p>Complaint IN00093147-Substantiated, federal/state deficiencies related to the allegations are cited at F224, F328, and F514.</p> <p>Survey dates: July 13 & 14, 2011</p> <p>Facility number: 010666 Provider number: 155664 AIM number: 200229930</p> <p>Survey team: Joyce Hofmann, RN</p> <p>Census bed type: SNF/NF: 101 Total: 101</p> <p>Census payor type: Medicare: 40 Medicaid: 32 Other: 29 Total: 101</p> <p>Sample: 3</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>			F0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0224 SS=D	<p>Quality Review completed on July 19, 2011 by Bev Faulkner, RN</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to ensure facility staff answered call lights in a timely manner for 3 of 9 resident council meeting minutes reviewed and 3 of 6 residents interviewed for call light concerns.</p> <p>Findings include:</p> <p>Resident call lights were observed on 07/13/11 during initial tour of the facility at 10 a.m. until 11:15 a.m.. Call lights were observed to be answered right away and no call lights were on for any extended period of time.</p> <p>Resident call lights were observed on 07/14/11 at 4 p.m., and was answered immediately by the Assistant Director of Nursing [ADON].</p> <p>Interview with Resident #D on 07/13/11 at 12:15 p.m., indicated the call lights are answered okay during the week, but on the week-ends sometimes it takes up to 30</p>			F0224	<p>Enclosed, please find our plan of correction for the deficiencies as identified during the complaint survey of July 14, 2011. The facility respectfully requests a desk review of our plan of correction. We believe that historically we have demonstrated commitment to our plans of correction and that we have delivered consistent quality outcomes. We would appreciate your consideration of this request. It is the practice of the facility to do everything within our power to prohibit the mistreatment, neglect, and abuse of residents and misappropriation of resident property. 1. Resident #D and #E no longer reside in the facility. Resident #H has been monitored routinely to help ensure call light is being answered more promptly. Resident #H's roommate #I stated during interview by State and DNS on 7/15/10 that call light is being answered by staff within timeframe of 2 to 5 minutes or faster. 2. The facility will continue to conduct call light audits on all shifts to include weekends by department managers and review</p>		08/02/2011

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	<p>minutes for the staff to answer as the staffing seems to be less on the week-ends.</p> <p>Interview with Resident #E on 07/13/11 at 12:55 p.m., indicated call lights are answered most of times up to 30 - 40 minutes or longer, week-ends are bad, they don't have staff on week-ends as they are few and far between.</p> <p>Interview with Resident #F on 07/14/11 at 4:10 p.m., indicated it takes staff 5 to 10 minutes to answer his call light.</p> <p>Interview with Resident G on 07/14/11 at 5:30 p.m., indicated it takes staff 10 minutes at most, usually less.</p> <p>Interview with Resident H on 07/14/11 at 5:31 p.m., indicated it takes sometimes 15 minutes, 30 minutes once in a while.</p> <p>Interview with Resident I on 07/15/11 at 5:32 p.m., indicated it takes staff 2 to 5 minutes or faster to answer call lights.</p> <p>Resident Council Meeting Minutes, dated 10/22/10, indicated the call lights were being answered better.</p> <p>Resident Council Meeting Minutes, dated 11/26/10, indicated one resident indicated call lights were not being answered</p>				<p>monthly in resident council meeting to determine if other possible call light concerns have been identified. The Administrator and/or designee will investigate identified concerns and assure individualized follow through. Resident Council Meeting 7/29/11 showed no call light concerns identified.3. The Staff Development Coordinator re-educated staff on 3/11/11, 6/6/11 and again on 7/14/11 to include weekend staff on 7/16/11 on call light policy and procedure. It is standard practice for facility to review call light policy and procedures quarterly. ADNS met with resident council on 6/24/11 to review the Call Light Policy and to assure them that the facility and its management take this policy very serious and will continue to ensure call lights answered timely.4. Administrator will review call light audits in monthly Quality Assurance meeting for the next three months and quarterly thereafter to ensure and monitor quality compliance.5. Administrator will ensure compliance by 8/2/11.</p>		

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	<p>timely.</p> <p>Resident Council Meeting Minutes, dated 12/17/10, indicated no call light concerns.</p> <p>Resident Council Meeting Minutes, dated 01/28/11, indicated call lights needed to be answered timely and it was worse on 2nd and 3rd shifts.</p> <p>Resident Council Meeting Minutes, dated 02/23/11, indicated call lights needed to be answered timely and indicated 1/2 hour wait at least to be answered.</p> <p>Resident Council Meeting Minutes, dated 03/25/11 and 05/27/11, indicated no call light concerns.</p> <p>Resident Council Meeting Minutes, dated 06/24/11, three residents indicated the staff cut off the call lights and do not come back. The notes indicated an audit on call lights on night shift was completed and all concerns had been addressed. The notes indicated the residents were pleased and had no further concerns.</p> <p>Review of the facility's policy on call lights entitled, Use of Call Light, dated 09/26/03, indicated, "Rationale The call light is a communication tool for the resident to request assistance." The Procedure for Responding to a Call Light</p>						

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	<p>indicated, "Identify the location of the light, and answer the resident promptly. ... Go to the location of the call light, and turn off the light. ... Assist resident with his/her needs, unless resident needs assistance with an activity that requires the assistance of a licensed nurse or nursing assistant. ... When finished, replace call light within resident's reach."</p> <p>Review of the facility's policy on Abuse dated 10/31/09, indicated, "Policy Verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, and neglect of the resident as well as mistreatment, neglect, and misappropriation of resident property are strictly prohibited.</p> <p>On 07/14/11 at 10:38 a.m., the Administrator presented a Call Light Study documentation of an audit conducted by the facility which indicated, "Over the past week the facility has conducted a call light study. In this study there were 67 call lights answered. Of the 67 call lights answered we as a facility are averaging a call light response time of 3.5 minutes. There were 7 responses within the 67 answered that were over 5 minutes, which means that 10% of call lights answered take longer than 5 minutes to answer."</p>						

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F0328 SS=D	<p>This federal tag is related to Complaint IN00093147.</p> <p>3.1-27(a)(3)</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on interview and record review, the facility failed to appropriately assess and document a resident's condition after choking while on leave of absence and 911 having been called and also failed to assess a resident's condition after having been down-sized to a new trach size and who felt the need to be frequently suctioned for 1 of 3 residents reviewed in a sample of 3 for tracheotomy care and assessment. [Resident #B]</p> <p>Findings include:</p> <p>1). Resident #B's closed clinical record was reviewed on 07/13/2011 at 12 p.m., and indicated the resident was admitted to the facility on 11/12/2010 and had diagnoses which included, but were not limited to, end stage renal disease with</p>		F0328	<p>It is the practice of the facility to ensure that residents receive proper treatment and care for special services.1. Resident # B no longer resides at facility.2. There were no other residents with trachs affected with not appropriately assessing and documenting tracheostomy care upon review.3. Nursing staff has been re-educated on 10-25-10, 11-30-10, 12-4-10, 4-25-11, 6-30-11,7-16-11 and most recently on 8-1-11 on the importance on assessing and documenting on residents with trachs. Unit Managers/ADNS and/or designee daily reviews trach residents to ensure appropriate documentation is completed and resident is being assessed when changes to trach have been made and/or care has been changed to include prior to and upon return from LOA.4. The</p>		08/02/2011	

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	<p>dialysis, secondary to diabetic neuropathy, hypertensive nephrosclerosis, acute respiratory failure, diabetes, trachea malasia, bacteremia secondary to methacillin resistant staphylococcus aureus, chronic obstructive pulmonary disease, hypertension, gastroesophageal reflux disorder, obesity, stage I diastolic heart function, and left toes amputee.</p> <p>Resident #B's hospital records, dated 11/02/2010, indicated the resident had been on hemodialysis for six years and had received a left transmetatarsal amputation on 10/13/2010 for gangrene and the resident had a Taylo-Achilles lengthening percutaneous of the left Achilles tendon. The resident's past diagnoses included, but were not limited to, tracheal malasia with prior reconstruction, status post tracheotomy in August 2010, dyslipidemia, status post recent cardiac and respiratory arrest, when the resident received the trach, and multiple recent resuscitations.</p> <p>Admission physician orders, dated 11/12/10, indicated orders which included, but were not limited to, trach care every shift, suction every shift as needed [prn], and oxygen [o2] at 4 liters with humidity 28%.</p> <p>Resident Progress Notes dated 11/12/10,</p>				<p>Director of Nursing is conducting weekly audits of chart documentation to help monitor for continued compliance and will report findings to Quality Assurance meeting for the next three months and quarterly thereafter. The Director of Nursing weekly audits consist of assessment and documenting on tracheostomy care patients to include prior to and upon return from LOA, threshold will be met when consistent documentation and assessment on all trachs patients remain in place on an ongoing basis and monitored on a quarterly basis to ensure continued compliance.5. Director of Nursing will ensure compliance by 8-2-11.</p>		

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	<p>indicated, "... Trach in place suctioned several times this shift. Resident encouraged to cough...."</p> <p>Resident Progress Notes, dated 11/13/10, indicated, "Neb [Nebulizer] txs [treatments] admin. [administered]. Suctioned x [times] 1. Pt. [Patient] able to cough up some sputum...."</p> <p>Resident Progress Notes, dated 11/14/10, indicated, "...lung sounds congested upper lobes...."</p> <p>Resident Progress Notes, dated 11/15/10, indicated, "Res. suctioned x 3 this shift secretions thick c [with] blood present...."</p> <p>Physician Telephone Orders, dated 11/15/10, indicated, "(1) Trach in place is a #6 Shirley cuffless, place spare @ [at] bedside. (2) O2 24% per trach mask c [with] O2 flow @ 3 lpm [liters per minute] (3) Suction trach q [every] 4 hours & prn, place ambu @ bedside (4) Lavage c normal saline @ times of sx [signs and symptoms] as needed. (5) R. T. [Respiratory Therapy] to change trach q monthly (6) Check O2 sats q shift & prn."</p> <p>Resident Progress Notes, dated 11/18/10, indicated, "Resident request cough syrup - states "I've been going to Dialysis s</p>						

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	<p>[without] a coat - now I have a cough" left lung rhonci"</p> <p>Resident Progress Notes, dated 11/20/2010, indicated, "... pt. [patient] states she has not been able to tolerate capping - feels she can't breathe when on.</p> <p>Resident Progress Notes, dated 11/21/10, indicated, "...Has only needed to be suctioned x 1 - after pt. swallowed some food that "went down the wrong pipe."</p> <p>Resident Progress Notes, dated 11/24/10, indicated, "Res. A [Alert] & O [Oriented] x 3, res. has thick secretions et may need additional breathing tx to loosen secretions. No c/o [complaint of] SOB [shortness of breath] or pain. Resp. [Respirations] even et non-labored...."</p> <p>The closed clinical record indicated a Release of Responsibility for Leave of Absence for Resident #B with a sign out date of 11/25/10 at 5 p.m.</p> <p>Interview with the complainant on 07/14/11 at 11:25 a.m., indicated on 11/25/10 the resident left the facility for Thanksgiving with family. The complainant indicated the resident got something stuck in her throat, 911 was called and the resident was suctioned. The emergency crew had no normal saline</p>						

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	<p>to help with the lavaging. The complainant's sister called the facility to let them know what was going on and asked if they should bring the resident back to the facility. The family was told by staff that the resident should be alright and they could keep her until midnight.</p> <p>Interview with LPN #3 on 07/13/11 at 4:50 p.m., indicated she recalled Resident #B going out and they were at home and called the facility and said the resident was eating chicken and got choked and asked if they should bring her back to the facility or call 911. LPN #3 indicated she told them if the resident was choking, call 911.</p> <p>Interview with the complainant's sister on 07/14/11 at 12 p.m., indicated the resident started coughing and coughing again and her cousin called 911 and the paramedics came and suctioned the resident and got out what they could as they did not have normal saline. The complainant's sister indicated she and her son returned the resident to the facility and when she arrived she called the facility to have someone meet them to help get the resident into the facility. The complainant's sister indicated they waited 15 minutes and no one showed up and her son got the resident out and into the facility. The complainant's sister</p>						

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	<p>indicated no one came to suction the resident and she put the resident's night clothes on her and left the facility. The complainant's sister called her that night and told her what was in the cannula and indicated it was something green and the resident had eaten greens for supper.</p> <p>Interview with LPN #2 on 07/14/11 at 12:42 p.m., indicated Resident #B did leave the facility on Thanksgiving and recalled her coming back to the facility and somebody from out staff was with them. LPN #2 indicated the resident wanted to be suctioned and had her portable oxygen with her. LPN #2 indicated she suctioned the resident and she had a mucous plug, pretty good size, color was dark brown and mucousy. LPN #2 indicated she cleaned and took out the inner cannula and changed it out and showed it to the resident. LPN #2 indicated the resident was fine after that. LPN #2 indicated family was in the room at the time of suctioning. LPN #2 indicated Resident #B always wanted suctioned and would get panicky and want suctioned again. LPN #2 indicated they were trying to wean the resident off, trying to cap her off, and she couldn't stand to be capped off. LPN #2 indicated the sisters were concerned we were not suctioning her, because the resident got so anxious.</p>						

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	<p>LPN #2 indicated in interview on 07/15/11 at 10:30 a.m., that she went straight into the room with the resident and family when they returned to the facility Thanksgiving night. The resident was in no distress and I suctioned the resident and the family was right there.</p> <p>The clinical record lacked documentation of resident assessment before the resident left the facility, what happened on leave of absence, and when she returned to the facility.</p> <p>The resident's clinical record lacked documentation of the resident's leave of absence, the incident at home and 911 having to be called, and them not being able to thoroughly suction the resident, and the call from the family in regards to telephoning the facility about bring the resident back and asking for assistance to bring the resident back into the facility.</p> <p>Resident Progress Notes, dated 11/27/10, indicated, "... Pt. states she has the most trouble after swallowing food that gets stuck in her throat. Has worn PMV valve throughout day - tolerates well. Pt states she has not been able to tolerate being capped off because she feels she can't breathe...."</p>						

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	<p>Resident Progress Notes, dated 11/28/10, indicated, "... Needed suctioning x [times] 1 only this shift - a small piece of food or thick mucous that she couldn't cough up...."</p> <p>Resident Progress Notes, dated 11/29/10, indicated, "... Resident c/o [complained of] not being able to cough out secretions. Neb [Nebulizer] Tx [Treatment] administered then suctioned c little help. Trach lavaged and suctioned again. A large thick mucous plug dislodged. Inner cannula changed and resident resting c no further complaints.</p> <p>Physician Telephone Orders, dated 11/30/10, indicated, "(1) Downsize trach to #4 Shirley cuffless (2) Cap trach c red cap during the day as tolerated, Remove trach cap @ noc [night] or if not tolerated during the day. (SOB [shortness of breath, dryness) (3) O2 2lpm per NC [nasal cannula] prn while trach is capped if O2 stats are <88%."</p> <p>Resident #B's Respiratory Assessment, dated 11/30/10, indicated the resident was alert, respiration rate of 16, heart rate 78, breathing pattern unlabored, o2 room air rest at 98%, breath sounds clear and decreased, trach size #4 Shirley changed on 11/30/10, trach weaning PMV cap, stoma site normal, trach position midline,</p>						

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	<p>no drain sponge, and no suction. The needs/comments section indicated, "Resident is in her room c ST [Speech Therapy] @ beside having a therapy session. Writer explained to res [resident] that her trach change was due. Res. verbalizes understanding. Trach changed @ this time to #4 Shirley cuffless. Change went well c no complications. p [After] trach change writer explained trach capping to res. Res verbalizes understanding but is reluctant to try, but will attempt. Trach capped @ this time c red cap. No distress or complications noted. Nursing informed of changes."</p> <p>There was no nursing assessment documentation of resident assessment in the Resident Progress Notes, dated 11/30/10, after down-sizing the trach nor being notified by RT in regards to the downsizing in the trach size.</p> <p>Resident #B's closed clinical record lacked documentation of nursing assessment on all 3 shifts for this resident on 11/30/10 even though Medication Administration Records [MAR] were documented correctly as having provided trach care, suctioning, and O2 sats and Speech Therapy and Respiratory Therapy had seen the resident that day.</p> <p>The next entry is dated 12/01/10 which</p>						

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	<p>indicated, "Resident returned from Dialysis. V/S [Vital signs] 160/85, hr [heart rate] 80 r [respirations] 16 t [temperature] 97 94% O2 sat, eating lunch, states "Not finished, I think I need to be suctioned." Suctioned resident x's 3 - c little (clear mucous) return, changed cannula. States "It feels better now." Resident coughed clear mucous into tissue. Encouraged to cough & spit often."</p> <p>Another Resident Progress Note, dated 12/01/10 at 2:20 a.m., which indicated, "Reported Trach info to eve [evening] shift nurse - ... Also explained that ... R. T. states resident is very apprehensive concerning trach & capping. Continue to encourage resident to "cough up" as much as possible." This entry was noted to be out of order as it was written on the back of notes dated 12/02/10.</p> <p>Interview with LPN #1 on 07/13/11 at 2:45 p.m., indicated the above entry was a late entry and should have been circled. LPN #1 went on the indicate the resident would not leave the cap on and she was really anxious.</p> <p>Interview with the Respiratory Therapist [RT], on 07/13/11 at 3:10 p.m., indicated he had changed the resident's trach on 11/30/10, as it was impeding her airway,</p>						

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	<p>but indicated he could not remember which nurse he talked to when he passed on the information to nursing. The RT indicated he assesses the resident and addresses any issues the resident might have. The RT indicated he was never notified by nursing for any concerns, but indicated if a nurse comes to him, he goes and assesses the resident and provides services if there is concerns.</p> <p>The facility's policy for Documentation of Resident's Health Status, Needs and Services, with revised date of 10/31/09, indicated, "Rationale The resident's medical record is a continuing account of the resident's health status and needs, the treatments delivered, results of diagnostic tests and the resident's response to treatment. The Interdisciplinary Team involved in the care of the resident is responsible for recording assessments of a resident's condition, changes in the resident's condition, a detailed accounting of interventions and an evaluation of the resident's progress toward established outcomes. Routine, periodic review of a resident's health status may be required per state regulation." The policy's Procedure indicated, "... Document as soon as the resident's encounter is concluded to ensure accurate recall of the data. ... Documentation in a resident's medical record should be: a. Consistent</p>						

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	<p>with the care plan b. Descriptive, c. Objective, d. Factual, e. Accurate, f. Organized, g. Complete, and h. Timely...." The Procedure also indicated, "... record pertinent resident data that may include but not limited to: a. change in condition/illness and ongoing monitoring b. Selected subjective data that validates or clarifies c. Action taken d. Notification of physician (name and status) e. Notification of family (name and relation to resident) f. Results of labs and follow-up g. Consultations h. Any unusual or abnormal occurrence i. All telephone calls made or received that are related to the resident j. Refusals, noncompliance, behavior occurrences k. Events and accidents - document the details of the event, action taken, notifications, monitoring, and follow-ups. l. Communication with others regarding the resident..."</p> <p>This federal tag is related to Complaint IN00093147.</p> <p>3.1-47(a)(6)</p>						

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F0514 SS=D	<p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to document in a resident's clinical record, resident progress notes of a resident's assessment and condition who had been down-sized to a new trach and who felt the need to be frequently suctioned, and failed to document a resident's assessment of condition before a leave of absence and after return to the facility after an incident in which 911 had to be called out for suctioning of the resident's trachea for 1 of 3 residents reviewed in a sample of 3 for tracheotomy care and assessment. [Resident #B]</p> <p>Findings include:</p> <p>1). Resident #B's closed clinical record was reviewed on 07/13/2011 at 12 p.m., and indicated the resident was admitted to the facility on 11/12/2010 and had diagnoses which included, but were not limited to, end stage renal disease with dialysis, secondary to diabetic neuropathy,</p>		F0514	<p>It is the practice of this facility to maintain clinical records on each resident and to document in a resident's clinical record, resident progress notes of a resident's assessment and condition who have been down-sized to a new trach.1. Resident # B no longer resides at facility.2. There were no other residents with trachs affected with not appropriately assessing and documenting tracheostomy care upon review.3. Nursing staff has been re-educated on 10-25-10, 11-30-10, 12-4-10, 4-25-11, 6-30-11,7-16-11 and most recently on 8-1-11 on the importance on assessing and documenting on residents with trachs. Unit Managers/ADNS and/or designee daily reviews trach residents to ensure appropriate documentation is completed and resident is being assessed when changes to trach have been made and/or care has been changed.4. The Director of Nursing is conducting weekly audits of chart documentation to</p>		08/02/2011	

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	<p>hypertensive nephrosclerosis, acute respiratory failure, diabetes, trachea malasia, bacteremia secondary to methacillin resistant staphylococcus aureus, chronic obstructive pulmonary disease, hypertension, gastroesophageal reflux disorder, obesity, stage I diastolic heart function, and left toes amputee.</p> <p>Resident #B's hospital records, dated 11/02/2010, indicated the resident had been on hemodialysis for six years and had received a left transmetatarsal amputation on 10/13/2010 for gangrene and the resident had a Taylo-Achilles lengthening percutaneous of the left Achilles tendon. The resident's past diagnoses included, but were not limited to, tracheal malasia with prior reconstruction, status post tracheotomy in August 2010, dyslipidemia, status post recent cardiac and respiratory arrest, when the resident received the trach, and multiple recent resuscitations.</p> <p>Admission physician orders, dated 11/12/10, indicated orders which included, but were not limited to, trach care every shift, suction every shift as needed [prn] and oxygen [o2] at 4 liters with humidity 28%.</p> <p>Resident Progress Notes, dated 11//12/10, indicated, "... Trach in place suctioned</p>				<p>help monitor for continued compliance and will report findings to Quality Assurance meeting for the next three months and quarterly thereafter. The Director of Nursing weekly audits consist of assessment and documenting on tracheostomy care patients to include prior to and upon return from LOA, threshold will be met when consistent documentation and assessment on all trachs patients remain in place on an ongoing basis and monitored on a quarterly basis to ensure continued compliance. 5. Director of Nursing will ensure compliance by 8-2-11.</p>		

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	<p>several times this shift. Resident encouraged to cough...."</p> <p>Resident Progress Notes, dated 11/13/10, indicated, "Neb [Nebulizer] txs [treatments] admin. [administered]. Suctioned x [times] 1. Pt. [Patient] able to cough up some sputum...."</p> <p>Resident Progress Notes, dated 11/14/10, indicated, "...lung sounds congested upper lobes...."</p> <p>Resident Progress Notes, dated 11/15/10, indicated, "Res. suctioned x 3 this shift secretions thick c [with] blood present...."</p> <p>Physician Telephone Orders, dated 11/15/10, indicated, "(1) Trach in place is a #6 Shirley cuffless, place spare @ [at] bedside. (2) O2 24% per trach mask c [with] O2 flow @ 3 lpm [liters per minute] (3) Suction trach q [every] 4 hours & prn, place ambu @ bedside (4) Lavage c normal saline @ times of sx [signs and symptoms] as needed. (5) R. T. [Respiratory Therapy] to change trach q monthly (6) Check O2 sats q shift & prn."</p> <p>Resident Progress Notes, dated 11/18/10, indicated, "Resident request cough syrup - states "I've been going to Dialysis s [without] a coat - now I have a cough"</p>						

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	<p>left lung rhonci"</p> <p>Resident Progress Notes, dated 11/20/2010, indicated, "... pt. [patient] states she has not been able to tolerate capping - feels she can't breathe when on.</p> <p>Resident Progress Notes dated 11/21/10 indicated, "...Has only needed to be suctioned x 1 - after pt. swallowed some food that "went down the wrong pipe."</p> <p>Resident Progress Notes dated 11/24/10 indicated, "Res. A [Alert] & O [Oriented] x 3, res. has thick secretions et may need additional breathing tx to loosen secretions. No c/o [complaint of] SOB [shortness of breath] or pain. Resp. [Respirations] even et non-labored...."</p> <p>The closed clinical record indicated a Release of Responsibility for Leave of Absence for Resident #B with a sign out date of 11/25/10 at 5 p.m.</p> <p>Interview with the complainant on 07/14/11 at 11:25 a.m., indicated on 11/25/10 the resident left the facility for Thanksgiving with family. The complainant indicated the resident got something stuck in her throat, 911 was called and the resident was suctioned. The emergency crew had no normal saline to help with the lavaging. The</p>						

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	<p>complainant's sister called the facility to let them know what was going on and asked if they should bring the resident back to the facility. The family was told by staff that the resident should be alright and they could keep her until midnight.</p> <p>Interview with LPN #3 on 07/13/11 at 4:50 p.m., indicated she recalled Resident #B going out and they were at home and called the facility and said the resident was eating chicken and got choked and asked if they should bring her back to the facility or call 911. LPN #3 indicated she told them if the resident was choking, call 911.</p> <p>Interview with the complainant's sister on 07/14/11 at 12 p.m., indicated the resident started coughing and coughing again and her cousin called 911 and the paramedics came and suctioned the resident and got out what they could as they did not have normal saline. The complainant's sister indicated she and her son returned the resident to the facility and when she arrived she called the facility to have someone meet them to help get the resident into the facility. The complainant's sister indicated they waited 15 minutes and no one showed up and her son got the resident out and into the facility. The complainant's sister indicated no one came to suction the</p>						

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	<p>resident and she put the resident's night clothes on her and left the facility. The complainant's sister called her that night and told her what was in the cannula and indicated it was something green and the resident had eaten greens for supper.</p> <p>Interview with LPN #2 on 07/14/11 at 12:42 p.m., indicated Resident #B did leave the facility on Thanksgiving and recalled her coming back to the facility and somebody from out staff was with them. LPN #2 indicated the resident wanted to be suctioned and had her portable oxygen with her. LPN #2 indicated she suctioned the resident and she had a mucous plug, pretty good size, color was dark brown and mucousy. LPN #2 indicated she cleaned and took out the inner cannula and changed it out and showed it to the resident. LPN #2 indicated the resident was fine after that. LPN #2 indicated family was in the room at the time of suctioning. LPN #2 indicated Resident #B always wanted suctioned and would get panicky and want suctioned again. LPN #2 indicated they were trying to wean the resident off, trying to cap her off, and she couldn't stand to be capped off. LPN #2 indicated the sisters were concerned we were not suctioning her, because the resident got so anxious.</p>						

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	<p>LPN #2 indicated in interview on 07/15/11 at 10:30 a.m., that she went straight into the room with the resident and family when they returned to the facility Thanksgiving night. "The resident was in no distress and I suctioned the resident and the family was right there."</p> <p>The resident's clinical record lacked documentation of the resident's leave of absence, the incident at home and 911 having to be called, and them not being able to thoroughly suction the resident, and the call from the family in regards to telephoning the facility about bringing the resident back and asking for assistance to bring the resident back into the facility. The clinical record lacked documentation of resident assessment before the resident left the facility, what happened on leave of absence, and when she returned to the facility.</p> <p>Resident Progress Notes, dated 11/27/10, indicated, "... Pt. states she has the most trouble after swallowing food that gets stuck in her throat. Has worn PMV valve throughout day - tolerates well. Pt states she has not been able to tolerate being capped off because she feels she can't breathe...."</p> <p>Resident Progress Notes, dated 11/28/10, indicated, "... Needed suctioning x [times]</p>						

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	<p>1 only this shift - a small piece of food or thick mucous that she couldn't cough up...."</p> <p>Resident Progress Notes, dated 11/29/10, indicated, "... Resident c/o [complained of] not being able to cough out secretions. Neb [Nebulizer] Tx [Treatment] administered then suctioned c little help. Trach lavaged and suctioned again. A large thick mucous plug dislodged. Inner cannula changed and resident resting c no further complaints.</p> <p>Physician Telephone Orders, dated 11/30/10, indicated, "(1) Downsize trach to #4 Shirley cuffless (2) Cap trach c red cap during the day as tolerated, Remove trach cap @ noc [night] or if not tolerated during the day. (SOB [shortness of breath, dryness) (3) O2 2lpm per NC [nasal cannula] prn while trach is capped if O2 stats are <88%."</p> <p>Resident #B's Respiratory Assessment, dated 11/30/10, indicated the resident was alert, respiration rate of 16, heart rate 78, breathing pattern unlabored, o2 room air rest at 98%, breath sounds clear and decreased, trach size #4 Shirley changed on 11/30/10, trach weaning PMV cap, stoma site normal, trach position midline, no drain sponge, and no suction. The needs/comments section indicated,</p>						

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	<p>"Resident is in her room c ST [Speech Therapy] @ beside having a therapy session. Writer explained to res [resident] that her trach change was due. Res. verbalizes understanding. Trach changed @ this time to #4 Shirley cuffless. Change went well c no complications. p [After] trach change writer explained trach capping to res. Res verbalizes understanding but is reluctant to try, but will attempt. Trach capped @ this time c red cap. No distress or complications noted. Nursing informed of changes."</p> <p>There was no nursing assessment documentation of resident assessment in the Resident Progress Notes dated 11/30/10 after down-sizing the trach nor being notified by RT in regards to the downsizing in the trach size.</p> <p>Resident #B's closed clinical record lacked documentation of nursing assessment on all 3 shifts for this resident on 11/30/10 even though Medication Administration Records [MAR] were documented correctly as having provided trach care, suctioning, and O2 sats and Speech Therapy and Respiratory Therapy had seen the resident that day.</p> <p>The next entry is dated 12/01/10, which indicated, "Resident returned from Dialysis. V/S [Vital signs] 160/85, hr</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 07/14/2011	
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	<p>[heart rate] 80 r [respirations] 16 t [temperature] 97 94% O2 sat, eating lunch, states "Not finished, I think I need to be suctioned." Suctioned resident x's 3 - c little (clear mucous) return, changed cannula. States "It feels better now." Resident coughed clear mucous into tissue. Encouraged to cough & spit often."</p> <p>Another Resident Progress Note, dated 12/01/10 at 2:20 a.m., which indicated, "Reported Trach info to eve [evening] shift nurse - ... Also explained that ... R. T. states resident is very apprehensive concerning trach & capping. Continue to encourage resident to "cough up" as much as possible." This entry was noted to be out of order as it was written on the back of notes dated 12/02/10.</p> <p>Interview with LPN #1 on 07/13/11 at 2:45 p.m., indicated the above entry was a late entry and should have been circled. LPN #1 went on the indicate the resident would not leave the cap on and she was really anxious.</p> <p>Interview with the Respiratory Therapist [RT], on 07/13/11 at 3:10 p.m., indicated he had changed the resident's trach on 11/30/10, as it was impeding her airway, but indicated he could not remember which nurse he talked to when he passed</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2011

FORM APPROVED

OMB NO. 0938-0391

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	<p>on the information to nursing. The RT indicated he assesses the resident and addresses any issues the resident might have. The RT indicated he was never notified, but indicated if a nurse comes to him, he goes and assesses the resident and provides services.</p> <p>The facility's policy for Documentation of Resident's Health Status, Needs and Services, with revised date of 10/31/09, indicated, "Rationale The resident's medical record is a continuing account of the resident's health status and needs, the treatments delivered, results of diagnostic tests and the resident's response to treatment. The Interdisciplinary Team involved in the care of the resident is responsible for recording assessments of a resident's condition, changes in the resident's condition, a detailed accounting of interventions and an evaluation of the resident's progress toward established outcomes. Routine, periodic review of a resident's health status may be required per state regulation." The policy's Procedure indicated, "... Document as soon as the resident's encounter is concluded to ensure accurate recall of the data. ... Documentation in a resident's medical record should be: a. Consistent with the care plan b. Descriptive, c. Objective, d. Factual, e. Accurate, f. Organized, g. Complete, and h.</p>						

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	<p>Timely...." The Procedure also indicated, "... record pertinent resident data that may include but not limited to: a. change in condition/illness and ongoing monitoring b. Selected subjective data that validates or clarifies c. Action taken d. Notification of physician (name and status) e. Notification of family (name and relation to resident) f. Results of labs and follow-up g. Consultations h. Any unusual or abnormal occurrence i. All telephone calls made or received that are related to the resident j. Refusals, noncompliance, behavior occurrences k. Events and accidents - document the details of the event, action taken, notifications, monitoring, and follow-ups. l. Communication with others regarding the resident..."</p> <p>This federal tag is related to Complaint IN00093147.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>						